CMS
Meeting of the Advisory Panel on APCs
January 22-23, 2002

Minutes of the Advisory Panel

on

AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS

Chartered and Appointed by the Secretary of the

U.S. Department of Health and Human Services

Convened at the CMS Central Office in

Baltimore, MD

on January 22 and 23, 2002

Attendees at the Two-Day Meeting

Members of the Panel
Paul Rudolf, MD, JD, Chair
Leslie Jane Collins, RN, BSN
Geneva Craig, RN, MA
Lora DeWald, MEd
Robert E. Henkin, MD
Lee H. Hilborne, MD
Stephen T. House, MD
Kathleen Kinslow, CRNA, EdD
Mike Metro, RN, BS
Gerald V. Naccarelli, MD
Beverly K. Philip, MD
Karen Rutledge, BS
William A. Van Decker, MD
Paul Wallner, DO

Other CMS Representatives
Tom Grissom, Director
Center for Medicare Management, CMS

Reporter
Dana Trevas

January 22, 2002: Day One

Introduction

The Panel Chair, Paul Rudolf, MD, JD, called the meeting to order at 9:15 a.m. Thomas Grissom, director for the Center for Medicare Management, welcomed the members to the second annual meeting and noted that the purpose of the APC Panel meeting was to discuss "what's in the APCs, what should be in the APCs, what are appropriate APCs, what kind of new APCs do we need, and what the relative resource intensity of those APCs should be." He emphasized that he, Secretary Thompson, and many others in the Department "think it is important that people outside of the Beltway and those who are involved in the provision of care be involved in the policy setting, policy making process."

Dr. Rudolf pointed out that the Panel is not authorized to raise the payments for a particular service. He said this meeting will focus on areas for which good claims data are available. Dr. Rudolf then invited Panel members and others to comment on issues from last year's meeting that were not included on this year's agenda.

2001 APC Recommendations and Other Issues

Dr. Rudolf noted that CMS attempts to provide reasonable reimbursement rates and to minimize the burden of coding; if specific APCs are "onerous," CMS will attempt to revise them as appropriate. Drs. House and Naccarelli brought up the APC code for observation: Dr. House felt it was cumbersome, while Dr. Naccarelli felt it should be expanded to include other diagnoses (e.g., abdominal pain, atrial fibrillation, and syncope). Dr. Rudolf agreed the observation APC should return to the agenda for the next meeting.

Dr. Wallner identified three issues for an upcoming agenda: 1) outliers to the "two-times rule" (i.e., within a given APC, the highest cost should be not more than two times the lowest cost), 2) multiple claims charges, and 3) the sufficiency of having only one meeting annually. Dr. Rudolf pointed out that the multiple claims charges were included on the current agenda and that violations of the two-times rule can be raised as individual APCs are discussed. As to more frequent meetings, Dr. Rudolf noted that regulations governing public meetings and agendas, the publishing of proposed rules, and the alowance of time for comments limit how often the Panel can meet. However, he agreed to explore the available options.

Ms. DeWald noted that, although education is recommended by CMS, the specific intent of some APCs is difficult to decipher, such as the APC on strapping and casting. Dr. Rudolf agreed some APCs were confusing, but added that "we need to know what the problems are before we can give guidance to solve them. And if that doesn't come out at this meeting, then maybe we'll have to find another mechanism for it to come out."

Subcommittee on Research Suggests Criteria for APC Evaluation

At last year's meeting, the APC Panel established the Subcommittee on Research to determine what kind of data are needed to evaluate APCs. The Subcommittee on Research recommended the following information be submitted from individuals or organizations wishing to make oral presentations on agenda items:

- A copy of the presentation
- Name, address, and telephone number of the proposed presenter
- Financial relationship(s), if any, with any company whose products, services, or procedures are under consideration
- CPT (Current Procedural Terminology) codes involved
- APC(s) affected
- Description of the issue
- Clinical description of the service under discussion, with comparison to other services within the APC
- Description of the resource inputs associated with the service under discussion, with a comparison to resource inputs for other services within the APC
- Recommendations and rationale for change
- Expected outcome of change and potential consequences of no change

Panel Recommendation: The Panel adopted the Subcommittee's criteria.

Review of Specific APCs

Nerve Injection (APCs 203, 204, 206, 207)

Dr. Laurie Feinberg, a physiatrist and medical officer from the CMS staff, noted these APCs still contain some violations of the two-times rule. However, she said, some variations will be resolved when further data are available from the review of the Medicare Outpatient Prospective Payment System (OPPS). It was noted that, as of November 2001, 75 percent of the costs of devices were incorporated into APCs, which may account for some violations of the two-times rule.

On behalf of the American Society of Interventional Pain Physicians (ASIPP), Arthur Didio and Vijay Singh raised concerns that payment for APC 207 does not adequately cover the costs of procedures included under that APC, probably because the costs are bundled with radiological services. As a result, hospitals and individual doctors have complained they are unable to provide some services, and patient access to those procedures has suffered, they said. In general, the ASIPP requests CMS analyze the impact on payment by multiple claims data. Mr. Didio suggested specialty societies like ASIPP could submit cost information, particular for APCs where single claims are few and multiple claims are high. Mr. Didio and Mr. Singh suggested APC 207 mixes both simple and complex procedures, and the reimbursement assumes that radiologic supervision and interpretation (S&I) occur with all the procedures in that code. The ASIPP recommended splitting APC 207 into two separate but clinically homogenous APCs.

Mr. Singh further noted that disk decompression and spinal endoscopy are "high-end procedures" currently included in APC 220, which does not cover the costs associated with these procedures. He asked for special consideration for these procedures. Mr. Didio added that programmable and nonprogrammable infusion pumps are both in APC 227, but the costs of the two types of devices can differ by as much as $4,000. Dr. Rudolf pointed out that both concerns were related to pass-through issues, which the Panel is not yet prepared to address but may consider in 2003.

Paul Radensky, an attorney whose firm represents Allergan, the manufacturer of Botox (botulinum toxin type A), asked the Panel to consider moving all the chemodenervation procedures into one APC code because (1) costs for those procedures are substantially more than those of other procedures in the various APCs to which they are now assigned and (2) all the chemodenervation procedures are clinically and economically similar. The Panel responded that no additional OPPS data are available to support that suggestion. Further, the ASIPP representatives noted that, although Botox costs more than other solutions, the procedure for injection is no different in terms of training, personnel, etc. The Panel again noted that pass-through payments are a distinct issue that will need to be addressed by the agency in the near future but cannot be addressed until the agency establishes a methodology that will apply to pass-through payments across the board.

Grace Kotowicz, director of CPT Editorial Research and Development at the American Medical Association (AMA), asked the Panel to consider separating trigger point and destruction chemodenervation procedures into different APCs because "the injection and the substances used for trigger point are different [from] the permanent-versus-temporary neurotoxic effect of the destruction and chemodenervation procedures. Therefore, the level of specificity of injection is greater versus trigger point, and therefore electromyography or other radiologic guidance is indeed used so as not to incur permanent impairment or temporary impairment."

Panel recommendations: The Panel recommends no change to the codes at present. In response to the ASIPP's request to split APC 207 into two codes, the Panel agrees the suggestion has merit and should be considered further when new claims data are available. The Panel asks that the topic be placed on next year's agenda.

Nerve and Muscle Tests (APCs 215, 216, 218)

Dr. Feinberg noted some APCs may appear to violate the two-times rule. However, she said, some variations will be resolved when further OPPS data are available. She noted this topic is among the areas in which "we need to be more specific about the kind of education needed."

CMS proposed the following to avoid violating the two-times rule:

Move HCPCS 95858, 95921, and 95922 from APC 215 to APC 218
Move HCPCS 95930 from APC 216 to 218
Move 92275 from 216 to 231
Move 95920 from 218 to 216

Alexander Fleming of Boston Medical Technologies testified that his company's system for measuring heart rate variability costs about $10,000 and requires a center to interpret the data using sophisticated algorithms; he said it is the most precise, accurate, reliable, and clinically useful test for measuring heart rate variability. It requires three physiologic maneuvers, and the clinical complexity and overall costs are not consistent with the CMS recommendation to move it to APC 218. Mr. Fleming requested the code be reassigned to APC 216, where it had been placed for calendar year 2000.

Dr. Henkin indicated the number of claims were few and there were no data on median costs; he noted, "If indeed your way is the best way to do this, then these devices are going to proliferate out there and we will have data at some point on what it costs to [measure heart rate variability] with your device." However, Dr. Henkin said, "The more we pay for something, the more likely it is to be used as well, and I'm a little afraid of getting the cart before the horse." Dr. Philips noted APC 216 has a higher reimbursement and would represent a "big jump." Ms. Kinslow said data were insufficient and suggested reevaluating the issue when further data are available.

Panel Recommendation: The Panel agreed with the revisions suggested by CMS staff. The Panel also agreed CMS should provide facilities with specific coding instructions for HCPCS 95904 that indicate it should be billed "per unit with multiple units," according to Dr. Rudolf, with a maximum number of units to be determined by CMS staff in consultation with experts in the field. In response to Boston Medical Technologies' request to map CPT code 95921 to APC 216, the Panel recommended no such change be made unless new data support such a move.

Closed Treatment Fracture/Dislocation Except Finger (APCs 43, 44)
Dr. Feinberg indicated many procedures in these APCs were of low volume. She feels the current data represent some miscoding, especially because some of the higher-cost procedures fall into the designation of "unlisted code." It was pointed out that several vertebral procedures were included in the category for finger, toe, and trunk procedures. Dr. Rudolf said a new APC for spinal procedures had been established.

Panel Recommendation: The Panel recommends no changes until further OPPS data are available. However, the Panel asked CMS to consider moving vertebral procedures to the new APC relating to the spine.

Strapping and Cast Applications (APCs 58, 59)
Dr. Feinberg wondered whether the APC for cast application is affected by the difference in cost between creating a cast and removing it; she acknowledged that application of this APC has been problematic. Ms. DeWald noted her organization gets more questions about these codes than any others and asked for better educational guidance from CMS.. The Chair suggested an outside organization convene a conference and offer specific suggestions to CMS on the problem and a resolution. A representative from the AMA pointed out it may be helpful to convene such a meeting in conjunction with revisions to the CPT manual.

A representative of the American Hospital Association (AHA) agreed more education is needed and asked that any educational document be authored and distributed by the CMS so that it carries more weight with providers.

Panel Recommendation: The Panel recommends no changes to the codes. However, the Panel recognizes that providers need further education in this area and suggests the AMA, AHA, or a similar organization arrange a meeting to discuss the issue, to which CMS should be invited. Recommendations from such a meeting could help CMS in developing a guidance document.

Emergency Visits and Clinic Visits (APCs 610, 611, 612)
As a result of an April 2000 rule, many details related to this area of care were left to the discretion of individual facilities. CMS staff compiled comments from facilities, drafted a report, and proposed various options to address those concerns. The options propose guidelines that use staff interventions, time, and/or point systems to correlate resource utilization and consumption with payment rates. The intent of the options was to provide a consistent coding method for all hospitals, to accurately reflect the resources used, to ensure appropriate staff skill levels are used, and to facilitate appropriate use of diagnostic and therapeutic interventions.

Nelly Leon-Chisen of the AHA recommended CMS adopt the American College of Emergency Physicians' (ACEP) methodology and establish temporary, HCPCS level-2 codes for reporting. Christian Downs of the Association of Community Cancer Centers emphasized the need for a uniform billing method. He proposed a five-level system to better pinpoint acuity and asked that various medical societies, including oncology nurses, evaluate the methodology before it is put into place. Ann Meehan, speaking on behalf of the Federation of American Hospitals, said the Federation would like the codes to distinguish physician resources from resources provided by facilities in the course of patient care; her organization supports a point system. After discussion by Panel members of the pros and cons of various methods, it was agreed that the system created by the ACEP and used by many hospitals for coding emergency visits would be a good model to emulate. The same model could be adapted for clinic visits.

Panel Recommendation: The Panel agrees that guidelines regarding emergency visits are needed and recommends using the ACEP system as a model for creating such guidelines. For clinic visits, the Panel recommends creating guidelines similar to the ACEP model, using one set of codes, distributed across five levels, for both new and established cases.

Angiography and Venography (APCs 279, 280)
Dr. Ken Simon of CMS explained these APCs seem to violate the two-times rule, but he believes that may be a function of anomalous data. Stephanie Mensh of AdvaMed complained that the current single claim database underreports the number of vascular procedures and that the assignment of status indicators unfairly affects the reimbursement level for some procedures.

She offered placement of stents as an example: because it is coded as a multiple service claim, the first procedure is fully reimbursed, while the second is reimbursed at only half the cost. She also asked that the Panel consider holding a public meeting when the claims data are available in order to discuss the impact of those data on reimbursement when devices are included in the billing.

Panel Recommendation: The Panel recommends no changes.

Cannula/Access Device Procedures (APC 115)
Dr. Simon explained this APC seems to violate the two-times rule, but he believes that may result from including the cost of the device. John Ross, MD, and Sajini Thomas of Medical Technology Partners presented information about the Lifesite cannula device and suggested it be categorized under an APC for new technology. They made no specific comments about APC 115. Dr. Rudolf indicated the Panel does not authorize new technology codes, nor does it "treat a procedure code differently because one piece of equipment is used instead of another."

Panel Recommendation: The Panel agrees no changes are needed until further OPPS data are available.

Vascular Repair/Fistula Construction (APC 93)
Dr. Simon explained this APC violates the two-times rule. The Chair pointed out the median cost for code 35226 was somewhat less than for other codes, but "if we were to move that, we would be underpaying it and potentially other direct blood vessel repairs."

Tom Byrne of Boston Scientific requested that CPT code 36780, percutaneous thrombectomy, be moved to APC 88, which includes other thrombectomy procedures, to improve clinical coherence. Panel members felt the other procedures in APC 88 were open procedures that are more labor-intensive and require more resources. Dr. Philip suggested Mr. Byrne provide data comparing the costs to facilities of providing the various procedures for the Panel to consider.

Panel Recommendation: The Panel recommends no changes.

Endoscopy (APCs 140, 141, 142, 143, 144, 145, 146, 147)
Dr. Simon explained some of these APCs violate the two-times rule, although in most cases the violation resulted when the costs of devices were incorporated. He noted the CMS should provide more guidance to facilities on applying these codes. The Chair indicated forthcoming data may help resolve some questions about these codes.

Miguel Valentin of Boston Scientific asked the Panel to consider that the use of single versus multiple service claims leads to underreporting of costs incurred by facilities. He recommended using multiple procedure information to determine payment rates when feasible. He also noted that because violations of the two-times rule are not always driven by new technology or pass-through devices, the rule should be more strictly enforced.

Panel Recommendation: The Panel recommends no changes but may wish to return to this item next year, if further data are available.

Anal/Rectal Procedures (APCs 148, 149, 150)
Dr. Simon indicated that upon review of these APCs, CMS staff finds these procedures to be clinically coherent and the levels of reimbursement appropriate.

Panel Recommendation: The Panel recommends no changes.

Otorhinolaryngologic Function Tests (APC 363)
The Chair explained this APC seems to violates the two-times rule, but CMS staff felt no changes should be made until further data are available. However, the staff also felt that moving HCPCS 92543, the caloric vestibular test, to the list of inpatient-only procedures would bring this code closer to satisfying the two-times rule. Panel members felt that the procedure is commonly performed on an outpatient basis and, since there had been no complaints about the code placement, there was no need to move it.

Panel Recommendation: The Panel recommends no changes.

Inpatient-Only List
Panel members discussed individual procedures they felt should be removed from the list, and Dr. House suggested abolishing the list altogether. All Panel members agreed problems arise in applying the definition of observation versus extended recovery and noted various situations in which patients are not formally admitted (e.g., death or transfer to another hospital). Ms. Craig emphasized that, regardless of how codes are applied, individual physicians are reimbursed for their services, while hospitals suffer from low or no reimbursement when coding problems arise.

The Panel members asked for more time to consider the specific procedures on the list provided. The Chair agreed to solicit input from the major medical societies with an interest in these procedures and distribute their comments to the Panel for further consideration.

Russell Miller of American Medical Systems suggested removing three procedures (CPT codes 53448, 54411, and 54417) related to insertion of penile prostheses from the inpatient-only list. The Chair pointed out that related medical societies determined those procedures all require a hospital stay of several days, and there are no data to suggest they could be performed on an outpatient basis.

Panel Recommendation: The Panel recommends no changes to the inpatient-only list at this time. The list should be considered again when input from major medical societies and providers is available. With regard to American Medical Systems' request to remove CPT codes 53448, 54411, and 54417 from the list, the Panel agreed no changes are needed unless further data support such a request.

Packaging of Radiologic Guidance/ S&I Codes

The Chair described the dilemma posed by packaging codes, particularly when such services as radiologic guidance, or S&I, are packaged with other codes. Some procedures and services, he indicated, are never performed alone; CMS believes reimbursement for such procedures and services will be more accurate, if they are always billed as multiple service claims. Dr. Rudolf gave the example of breast biopsy, which can be guided by magnetic resonance imaging (MRI), computed tomography (CT), ultrasonography, or stereotactic guidance; the cost of the procedure varies depending on the method of guidance used. However, CMS reasons that as long as a facility uses a range of methods of guidance, the overall costs average out. A major drawback to multiple service claims, however, is that the CMS database can only compute data using single service claims. CMS creates a "relative weight" for procedures, services, etc., based on single and multiple service claims; then a conversion formula is created to translate that weight into a dollar amount for reimbursement.

Panel members noted that hospitals do not itemize their costs when they receive reimbursement, so some departments or services are not reimbursed. Also, Dr. Henkin pointed out that packaging codes creates a disincentive to provide services; i.e, facilities receive the same reimbursement, even if they do not provide all the services included in the code.

Bill Thorworth of the American College of Radiology (ACR) echoed Dr. Henkin's concerns, adding that packaging "economically incentivizes the institution to do that for which they have a profit margin. ... It sets up a financial incentive that may be contrary to appropriate clinical care." He pointed out that when radiologic guidance codes are packaged, the radiology provider cannot adequately demonstrate to the facility that it is being reimbursed for the radiology services. Mr. Thorworth said the ACR recommends the guidance procedures be placed in the highest level to account for resource costs.

Junga Shah recommended separating the concept of packaging from the need to generate more single claim bills. Dr. Potters of the American Society for Therapeutic Radiology and Oncology (ASTRO) noted that expensive new technology is lumped into codes with much less expensive technology; therefore, new technology is not adequately reimbursed and facilities have an economic disincentive to use it. Henry Alder of Johnson & Johnson said his organization supports packaging for such procedures as breast biopsy and guidance. He said, "While the concept would work for an already existing technology, the packaging of APCs would perhaps work best ... for those technologies that have now left the new technology APCs and have been placed into unique APC categories."

Following these comments, the Chair adjourned the meeting for the day. Presentations on this topic resumed on Day Two.

January 23, 2002, Day Two:

Continued Discussion of Packaging of Radiologic Guidance/ S&I Codes
Carl Bogardus, MD, a radiation oncologist, and John Manzetti of NOMOS Corporation both requested that the HCPCS codes for ultrasonographic guidance for radiation treatment, which include NOMOS' BAT (B-mode acquisition and targeting system) ultrasound system, be removed from its current package. They argued that the equipment is more expensive and is more frequently employed in the course of a patient's treatment than other forms of guidance in the same APC. In addition, more BAT systems are in use now than in 1999, and so better data are available on the cost of using them. Albert Blumberg of ASTRO emphasized the need for addressing how data can be collected using information from multiple service claims.

The Chair summarized the perceived problems of bundling codes in relation to the inability of CMS or others to gather specific cost and use data for various components of a procedure and the inability of clinical facilities to track the provision of services. The Panel members agreed these problems applied to bundling codes across the board and not just in relation to guidance. Panel members agreed (1) that assigning an N status indicator to a code virtually ensures hospitals will stop using the code, (2) that packaging guidance procedures with others makes it difficult for departments providing guidance to get their share of the reimbursement, and (3) that packaging makes it difficult to track or evaluate the provision of individual services.

Panel Recommendation: The Panel recommends the radiologic guidance/S&I codes *not* be bundled and that CMS consider unbundling other services.

Multiple Bill Analysis: ERCP and Radiation
The Chair elaborated on the complications posed by multiple bill analysis, particularly because facilities all use different approaches to coding costs. Dr. Blumberg of ASTRO volunteered his organization to provide specialty-specific input on how services are performed and billed. Ms. Shah, speaking on behalf of Exempt Cancer Centers, proposed revising the methodology to look at only those claims in which line items can be clearly mapped to a CPT code. She suggested this would at least provide more data in some areas, even though many areas would still be left out. The Panel asked that CMS staff look into the feasibility of Ms. Shah's suggestion and report back to the Subcommittee on Research.

Dr. Wallner summarized the recommendations of the Subcommittee on Research as follows.

- CMS should continue to explore the use of multiple claims data for setting payment rates but continue to use only single procedure claims data for rate setting for calendar year 2003.
- CMS should work with the APC Technical Panel to explore the use of multiple claims data drawn from OPPS claims for services, such as radiation oncology, in time for the next APC Panel meeting.

- CMS should educate hospitals on appropriate coding and billing practices to ensure that claims with multiple procedures are properly coded and that costs are properly allocated to each procedure.

Panel Recommendation: The Panel agrees with the recommendations of the Subcommittee on Research.

Diagnostic Ultrasound (APCs 96, 265, 266, 267, 269, 270)
The Society of Diagnostic Registered Vascular Technicians (SDRVT) requested the Panel review these APCs and proposed reordering based on resource utilization similarities. Their proposal creates several violations of the two-times rule and results in several APCs with only one or two HCPCS codes. Terry Deutsch of CMS indicated only APCs 96 and 265 currently violate the two-times rule. CMS staff indicated data do not support the SDRVT proposed structure.

Bill Sirrell and Ann Jones, representing the Society of Vascular Technology, the Society of Diagnostic Medical Sonography, and the American Society of Neuroimaging, presented a proposal for reordering these APCs. Ms. Jones indicated the APCs are grouped by CPT codes based on anatomical sites, ignoring the clinical similarities (in personnel and equipment) of various types of exams. In addition, Ms. Jones claims sonographers are being pressured to perform less extensive examinations because their facilities are not reimbursed appropriately for more detailed examinations. The proposal creates three levels of exams by complexity. It does not address echocardiography. However, asked whether vascular and nonvascular ultrasonography could be segregated, Ms. Jones stated the personnel and procedures are the same for both. Pam Kassing of the ACR noted her organization is a major stakeholder in issues related to ultrasonography and would like to have time to offer input on the proposal. The Panel members felt the proposal was a good starting point but that many more interested parties should review it and the long-term ramifications of the proposed changes should be more deeply scrutinized.

Nicole Doober of Boston Scientific noted intravascular ultrasound is a catheter-based imaging technology that allows the clinician to view vessels from within; the preparation time and anesthesia requirements are different from those for external vascular ultrasonography. She recommended moving intravascular ultrasound out of APC 267 on the basis that it is not clinically homogeneous with other items in that APC. Dr. Naccarelli agreed with Ms. Doober's assessment of the problem but said the question again goes to the larger issues of including the cost of a device in the reimbursement and of packaging diagnostic procedures with therapeutic intervention.

Panel Recommendation: The Panel recommends no changes. In response to the proposal presented by the Society of Vascular Technology, the Society of Diagnostic Medical Sonography, and the American Society of Neuroimaging, the Panel suggests the proposal be circulated to other interested parties for further comment and presented to the Panel for consideration next year.

Therapeutic and Miscellaneous Radiologic Procedures (APCs 296, 297, 263, 264)
Ms. Deutsch outlined three options proposed by CMS staff to rectify violations of the two-times rule and create APCs that are more clinically similar. Dr. Naccarelli pointed out that option B does not require the creation of any new APCs but that all of the options are essentially "cosmetic" improvements. Ms. Kassing of the ACR recommended that the CMS address the two "miscellaneous" APCs, either by creating new APCs for those items or by incorporating them into other existing APCs; however, she did not provide specific, concrete suggestions for revising the APCs.

Panel Recommendation: Of the options put forth by CMS staff, the Panel recommends adopting option B: Move HCPCS 76101, 70390, and 71060 (from APC 263) and HCPCS 75984 (from APC 296) to APC 264, and move HCPCS 75980 from APC 297 to APC 296. However, if the ACR or others wish to propose further changes, the Panel will consider them next year.

Diagnostic Nuclear Medicine (APCs 291, 292)
Gordon Schatz and Bill Uffelman of the Nuclear Medicine APC Task Force (a coalition of various medical specialty societies) asked the Panel to clarify the rationale behind recent changes to these APCs, noting the new categories did not adequately represent either clinical or resource homogeneity. They suggested creating a third APC.

Panel Recommendation: The Panel recommends no changes. In response to the Nuclear Medicine APC Task Force's request to split these two APCs into three APCs, the Panel said it may consider the issue next year, if a concrete proposal were provided.

Myelography (APC 274)
The Chair noted this APC was considered at last year's meeting. No questions or concerns were raised.

Panel Recommendation: The Panel makes no recommendations.

Add-On Codes
Dr. Van Decker noted the concerns raised by add-on codes are similar to those related to the packaging of S&I codes. As with the packaging of S&I codes, Dr. Henkin noted, the question of multiple versus single claims billing should be resolved before add-on codes can be addressed with sufficient data. None of the options proposed by CMS staff were felt to offer good solutions to the problems.

Panel Recommendation: The Panel makes no recommendations and asks that the Subcommittee on Research consider the issue.

Eye Procedures (APCs 230–242, 247, 248, 698, 699)
Dr. Simon asked the Panel to review the changes that had been made by the staff to address violations of the two-times rule and make the APCs more clinically cohesive.

The Chair noted that some of the APCs incorporated the costs of devices, which raises the larger question of whether a single APC should include procedures both with and without device costs. A representative of Alcon Laboratories, Inc., pointed out what she felt were errors in the previous APC codes. The Chair indicated that the changes already made addressed those errors and were approved by a staff ophthalmologist.

Panel Recommendation: The Panel supports the changes made by CMS staff to these APCs. The Panel also recommends the Subcommittee on Research consider whether a single APC should include procedures both with and without device costs.

Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant (APCs 110, 111, 112, 113)

The Chair indicated the APCs now capture the cost of apheresis devices and addresses what were thought to be errors in the previous iteration. Robert Weinstein, MD, of the American Society for Hematology noted that APC 110 can be used to bill only once per procedure, even when multiple transfusions are needed. Unlike intravenous saline, he said, each unit of blood transfused requires starting from scratch, with additional product costs, staff time, etc. He requested that facilities be allowed to code for reimbursement for each blood product transfused.

Dr. Weinstein further noted, "Things like gamma globulin, prolastin, recombinant clotting factor, and plasma-derived clotting factor concentrate are indeed blood products or their recombinant analogs, and if they're held subject to the mandated reductions because they are pass-through items, there are going to be a lot of patients with expensive and complex clinical disorders that will find themselves unable to be treated because hospitals will not be able to afford the product." He asked that all blood products be treated the same and not as pass-through items.

Chris Mancill of the American Red Cross pointed out that, by definition, the procedure of blood transfusion always includes a blood product and therefore will always be a multiple service claim. As such, reliable data on blood transfusion will never be captured by the CMS database. The Red Cross recommends the Subcommittee on Research evaluate the issue to determine whether the relative weight used to set payment could address the CPT code for service instead of the HCPCS code.

Panel Recommendation: The Panel recommends plasma derivatives and whole blood products be categorized in the same manner and assigned the same status indicator (P) to ensure equivalent reimbursement and patient access.

The Panel agrees with the American Society for Hematology that facilities incur additional costs with each unit of blood product transfused. Therefore, the Panel recommends revising APC 110 to account for additional costs of the product and additional clinical services.

Regarding the issue of multiple service claims for blood transfusion, the Panel referred the issue to the Subcommittee on Research for consideration.

Insertion of Penile Prostheses (APCs 179, 182)
Dr. Simon noted these two new codes were added since the Panel last met and asked that the Panel review them. The Chair pointed out that the apparent violation of the two-times rule was caused by the incorporation of devices into the costs.

Russell Miller of American Medical Systems asked that the Panel consider moving HCPCS 53445 and 53448 from APC 179 to 182, where they would be more comparable, and that a status indicator of "S" be assigned to implant codes and to removal and replacement codes. He stated that many surgeons implant devices for erectile dysfunction and incontinence in one surgical procedure, to avoid additional burden to the patient, but the costs of the additional incision and device are not sufficiently reimbursed. CMS staff and Panel members felt data did not support the assertion that such simultaneous procedures are frequent. The Chair questioned why procedures on two different organs would be appropriate under the same APC. Dr. House and others felt the requests represented an attempt to recapture device costs, and the details of reimbursing for device costs need to be further clarified by CMS.

Panel Recommendation: The Panel recommends no changes.

Excision/Biopsy (APC 19, 20, 21, 22, 694)
The Chair indicated that CMS staff felt no changes were needed to these APCs.

Panel Recommendation: The Panel recommends no changes.

Skin Repair (APCs 24, 25, 26, 27, 686)
The Chair noted these APCs were reviewed at last year's meeting and that codes had been reorganized to avoid violations of the two-times rule. He noted that, contrary to what he and other Panel members suspected, these APCs were more likely to be applied to procedures performed in a clinic setting than in an emergency department.

Panel Recommendation: The Panel recommends no changes.

Pulmonary Treatment (APCs 77, 78)
The Chair noted one of these APCs does violate the two-times rule, but the result is minimal (about $1), so the CMS staff feels there is no reason to revise the codes.

Panel Recommendation: The Panel recommends no changes.

ENT Procedures (APCs 251, 252, 253, 254, 256)
The Chair noted these APCs are categorized in five levels but only level one seems to violate the two-times rule. The CMS staff has been unable to identify a better structure for this category. The Chair asked Panel members to consult with their colleagues who specialize in ear, nose, and throat procedures and ask for their input.

Panel Recommendation: The Panel recommends no changes until further OPPS data are available.

Packaging, Multiple Service Claims, Add-On Codes, and Pass-Through Payments Merit Further Discussion

Summarizing the work ahead for the Panel, the Chair noted that the Subcommittee on Research would further evaluate the questions raised throughout the meeting related to APCs and packaging (or bundling), multiple service claims, add-on codes, and pass-through payments (for devices). He noted any member of the Panel can take part in Subcommittee meetings. Methods of communication (e.g., teleconference and e-mail) were discussed. Dates for a possible second meeting in 2002 were also suggested but no date was set.

The meeting was adjourned at 4:00 p.m. on Wednesday, January 23.

Respectfully submitted by Dana Trevas
Thursday, February 21, 2002